North Carolina Department of Health & Human Services
State Treasurer's Electronic Payments System (STEPS)
Hospital ACH Data Set Up/Change Form

Form is submitted for: Please enter "yes" in field after "Initial Signup" or "Information Change" and enter date authorization is effective.	Initial Signup: (yes/no)	
	Information Change: (yes/no)	
	Date Effective:	

PROVIDER INFORMATION	
I.D. Number: **(DHHS use only)**	
Provider Number:	
Provider Name:	
Provider Address:	
Fax Number:	

FINANCIAL INSTITUTION ACCOUNT INFORMATION	
Institution Name:	
Institution Address:	
Transit/Routing Number:	
Bank Account Number: (include leading zeros)	
Type of Account: (checking or savings)	

PARTICIPATING ENTITY AUTHORIZATION:

On behalf of the provider indicated above, I am hereby authorizing the North Carolina State Treasurer, his successors and his agents, at the direction of the North Carolina Department of Health and Human Services (DHHS) to initiate ACH credit entries to the above designated bank account for payments from DHHS under the Medicaid Reimbursement Initiative (MRI). This authorization is to remain in effect until the Departments of Health and Human Services and State Treasurer receive written notification of subsequent changes authorized by the provider. I certify that I am an officer of the above named provider and that I have the banking authority to make this request/change on behalf of this provider.

Typed or Printed Name: _____ Title: _____ Phone: _____

Signature_____ Date_____

MAIL COMPLETED FORM TO:
NC Depart. of Health & Human Services
Division of Medical Assistance
Finance Management - 09
Att: Janet Choplin
2501 Mail Service Center
Raleigh, NC 27699-2501

DHHS Use Only:

State Treasurer Use Only: